



West Hills Hospital and Medical
Center
7300 Medical Center Drive
West Hills, CA 91307
Telephone: (818) 676-4999

KATHLEEN M GOLD
PatID: AF00745510 Age: 48
Acct#: AF1002257625 DOB: 12/17/1966
Printed: 08/21/2015 6:32 PM
By: Sanjay Bhatt, MD Lic: CA107513

After Care Instructions

INSTRUCTIONS

CHEST PAIN ETIOLOGY UNCLR

1. You have been seen for chest pain. The cause of your pain is not yet known.
2. Your doctor has learned about your medical history, examined you, and checked any tests that were done. Still, it is unclear why you are having pain. The doctor thinks there is only a very small chance that your pain is caused by a life-threatening condition. Later, your primary care doctor might do more tests or check you again.
3. Sometimes chest pain is caused by a dangerous condition, like a heart attack, aorta injury, blood clot in the lung, or collapsed lung. It is unlikely that your pain is caused by a life-threatening condition if: Your chest pain lasts only a few seconds at a time; you are not short of breath, nauseated (sick to your stomach), sweaty, or lightheaded; your pain gets worse when you twist or bend; your pain improves with exercise or hard work.
4. Chest pain is serious. It is VERY IMPORTANT that you follow up with your regular doctor and seek medical attention immediately here or at the nearest Emergency Department if your symptoms become worse or they change.
5. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:
 - Your pain gets worse.
 - Your pain makes you short of breath, nauseated, or sweaty.
 - Your pain gets worse when you walk, go up stairs, or exert yourself.
 - You feel weak, lightheaded, or faint.
 - It hurts to breathe.
 - Your leg swells.
 - Your symptoms get worse or you have new symptoms or concerns.



PATIENT COPY



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Center
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West Hills, CA 91307
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FOLLOW UP

Follow up with your physician 48 hours. Call as soon as possible to arrange.

STATEMENT

I certify that I have received a copy of the above after-care instructions; that these instructions have been explained to me; and that all of my questions pertaining to these instructions have been answered in a satisfactory manner.

Patient/Representative Signature: _____ Staff Signature: _____
Date: 08/21/2015



PATIENT COPY

SPECIALTY ROSTER ER PATIENT- PHYSICIAN REFERRAL LIST

NAME	ADDRESS	TELEPHONE
Internal Medicine		
Amini, Parviz M.D.	8435 Reseda Blvd. Northridge, CA 91324	818-998-6000
Cabello-Namazie, Giselle M.D.	1250 La Venta Drive, Suite 207 Westlake, CA 91361	805-494-6920
Darush, Alan M.D.	8540 Reseda Blvd. #103 Northridge, CA 91324	818-280-0700
✓ Diehl, Paul E. M.D.	7320 Woodlake Ave. #270 West Hills, CA 91307	818-347-1500
Ernzen-Kruger, Kellie M.D.	1250 La Venta Drive, Suite 207 Westlake, CA 91361	805-494-6920
Eshraghi, Rauz A. M.D.	1250 La Venta Drive, Suite 207 Westlake, CA 91361	805-494-6920
Faust, Irene B. M.D.	7345 Medical Center Dr. #200 West Hills, CA 91307	818-888-3416
Feghali, Nabil S. M.D.	8111 Canoga Ave. Canoga Park, CA 91304	818-704-7200
Ficks, Lauren G. M.D.	1250 La Venta Drive, Suite 207 Westlake, CA 91361	805-494-6920
Graham, Geoffrey L. M.D.	1534 N Moorpark Road Thousand Oaks, CA 91360	805-497-1800
Grosser, Jeremy I. M.D.	9301 Oakdale Ave. #200 Chatsworth, CA 91311	818-904-1244
✓ Hage, Christopher N. M.D.	7345 Medical Center Dr. #220 West Hills, CA 91307	818-702-9962
Hanson, Robert M.D.	22600 Ventura Blvd. #104 Woodland Hills, CA 91364	818-225-1617
Hirsch, Caleb W. M.D.	23101 Sherman Place #500 West Hills, CA 91307	818-676-4802
Hirt, Michael M.D.	5620 Wilbur Ave. #220 Tarzana, CA 91356	818-345-2828
Humayun, Saeed M.D.	23388 Mulholland Drive.-Med Staff Office Woodland Hills, CA 91364	818-876-4055
Iqbal, Mohammed I. M.D.	7345 Medical Center Dr., 6th floor West Hills, CA 91307	818-347-2921
Jacobson, Bruce A. M.D.	7301 Medical Center Dr. #404 West Hills, CA 91307	818-347-3239
Kohan, Sid M.D.	8510 Balboa Blvd., Suite 150 Northridge, CA 91325-5810	818-552-6230
Kurtz, Allan L. D.O.	6325 Topanga Canyon #501 Woodland Hills, CA 91367	818-346-1440
✓ Lavin, Marc I. M.D.	23101 Sherman Place #510 West Hills, CA 91307	818-676-4805
Leibzon, Roman M.D.	1250 La Venta Drive, Suite 207 Westlake, CA 91361	805-494-6920
Lin, Jay J. M.D.	22030 Sherman Way #201 Canoga Park, CA 91303	818-883-6840
London, Jeffrey M.D.	7345 Medical Center Dr. #600 West Hills, CA 91307	818-347-2921
Ma, Janet M. M.D.	1250 La Venta Drive, Suite 207 Westlake, CA 91361	805-494-6920
Menteer, Francoise G. M.D.	29525 Canwood Street #300 Agoura Hills, CA 91301	818-706-2477
Mortezai, Mina D.O.	22554 Ventura Blvd. #201 Woodland Hills, CA 91304	818-222-8042
Mortezai, Maryam D.O.	22554 Ventura Blvd. #201 Woodland Hills, CA 91364	818-222-8042
Moshfeghi, Narsis M.D.	7325 Medical Center Dr. #306 West Hills, CA 91307	818-703-7027
Nasim, Sohail M.D.	7230 Medical Center Dr. #302 West Hills, CA 91307	818-227-4272
Newmark, Shelese R. M.D.	1250 La Venta Drive, Suite 207 Westlake, CA 91361	805-494-6920
Nudell, Gary H. M.D.	23101 Sherman Place #510 West Hills, CA 91307	818-676-4806
Pimstone, Kevin R. M.D.	1250 La Venta Drive, Suite 207 Westlake, CA 91361	805-494-6920
Razeghi, Seyyed Mehdi M.D.	8510 Balboa Blvd., Suite 150 Northridge, CA 91325-5810	818-552-6230
Saedi, Golnaz M.D.	7320 Woodlake Ave. #170 West Hills, CA 91307	818-888-7090
Sahibzada, Afzal H. M.D.	22110 Roscoe Blvd. #301 West Hills, CA 91304	818-719-9117
Shaarawy, Rami M. M.D.	21822 Sherman Way #100 Canoga Park, CA 91303	818-716-0557
Shao, Maogang M.D.	8510 Balboa Blvd. #150 Northridge, CA 91325	818-654-3400

*Internal
Medicine*

*ADPP
MDVIP
Concierge
Cash*

7300 Medical Center Dr
West Hills, 91307

DATE	PATIENT	CODE	DIAG	DESCRIPTION OF SERVICES	AMOUNT
08/21/15	KATHLEEN	71010/26		XRAY:EXAM OF CHEST	\$50.00
				Claim 1 Total:	\$50.00

To pay this statement electronically go to
www.ePayitOnline.com or scan the barcode
to the right with your mobile device or tablet

SCAN FOR
MOBILE
PAYMENT



If you would like to pay using a credit card, please visit the secure web site noted at the top of this statement using the indicated Code ID and Access #. For your security purposes, please do not return this statement with your credit card information via the US Mail. If you would like to pay using a check, please detach the top portion of this statement and return it with your check to the address noted above.

Paid
9/11/2015
#2981
\$50.00

BALANCE DUE: \$50.00

ACCOUNT CONDITION: Current: \$50.00 30 Days: \$0.00 60 Days: \$0.00 90 Days: \$0.00 120 Days: \$0.00

Patient: KATHLEEN M GOLD

Account Number: WVR 10745510

Statement Date: 08/27/2015

Location: WEST HILLS HOSPITAL & M

THIS BILL IS DUE UPON RECEIPT. PLEASE MAIL YOUR
REMITTANCE IN THE ENCLOSED ENVELOPE. FOR
QUESTIONS PLEASE CALL OUR BILLING OFFICE AT 888
407 3975. THANKS

West Valley Radiology Med Group
PO Box 190
Simi Valley CA 93062

Phone: 888 407-3975

CMSINC01-0438038-0003934-4825500-001-000478-#004183-0001

BILLING & INSURANCE POLICY

You alone, not your insurance company, are responsible for payment of your account. If, after receiving this statement, you are unable to pay in full, you must contact our billing office. If you have reason to believe this billing is incorrect and desire to dispute it, you must notify us in writing within 30 days of receiving this billing. If we do not hear from you, we will expect prompt payment of this bill.

PLEASE NOTE: There may be a collection charge for checks that are not honored by your bank. Also, there may be a service charge added to past due accounts.

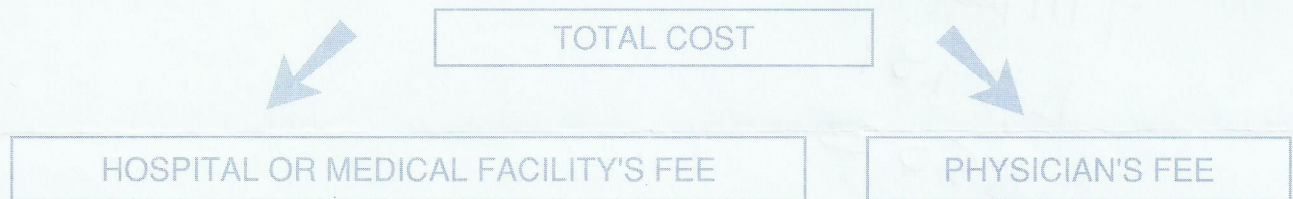
We will bill Medicare for you, however, you must provide us with your Medicare number and signed authorization form provided to you at the time of service. If a form was not provided then please sign in the area marked authorized signature above. You will receive a regular monthly billing for any balance owing after payment by Medicare.

IF YOU HAVE RECEIVED THE SERVICES OF A HOSPITAL OR OTHER MEDICAL FACILITY

YOU MAY RECEIVE TWO SEPARATE BILLS.

ONE FROM THE HOSPITAL OR MEDICAL FACILITY & ONE FROM THE PHYSICIAN PROVIDING SERVICES.

THE HOSPITAL OR OTHER MEDICAL FACILITY'S BILL MAY BE SEPARATE FROM THE PHYSICIAN'S BILL.

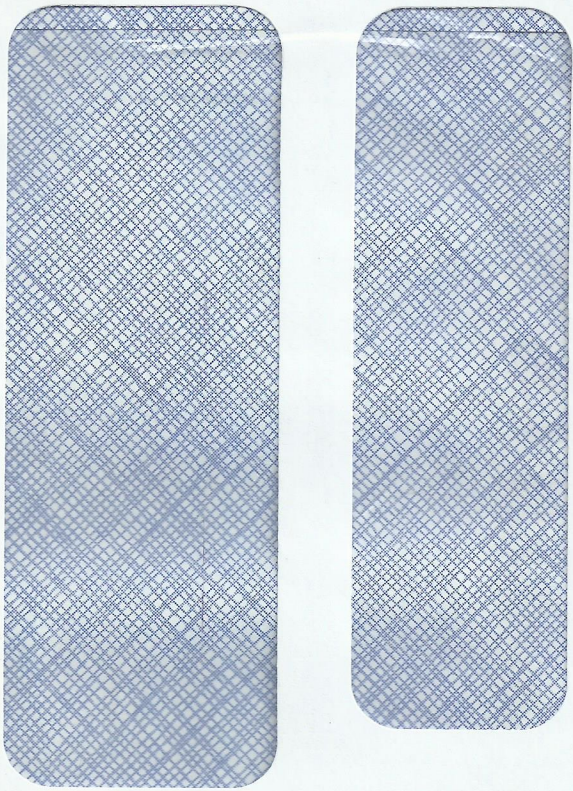


The total cost for many medical services may be comprised of two fees. Each fee may be billed separately by the provider of the services.

The hospital or other medical facility's fee covers the cost of providing the technicians, equipment and supplies involved in performance of your service.

The physician's fee is for services provided by your physician or for services provided by a physician for the supervision, interpretation and consultation with your personal physician. The physician is an independent physician and may not be an employee of a hospital or medical facility and therefore may bill separately for his or her professional service.

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U.S. POSTAGE PAID
MRH



44-SP1 91345



114505



PO BOX 409434
ATLANTA, GA 30384-9434

SSC08591 312469 187518423

KATHLEEN M GOLD

512

11100-8 SEPULVEDA BLVD

MISSION HILLS, CA 91345-1101

001022

We appreciate the opportunity to serve you!

Thank you for trusting us with your healthcare needs. We hope our care exceeded your expectations. Please contact us if we can be of further assistance.

Pay online at:

www.westhillshospital.com/bill.asp

Statement Date:

11/13/2015

Account Number:

1002257625

Page 1 of 1

ACCOUNT ACTIVITY

Account Number	1002257625
Date of Service	8/21/2015
Charges to Date	\$ 2,740.00
UNINSURED DISCO Discounts	- 2,329.00
Payments/Discounts to Date	- \$ 2,329.00
Remaining Account Balance	\$ 411.00
Amount Expected From Insurance	\$ 0.00

***AMOUNT YOU OWE \$ 411.00**

A MESSAGE FOR YOU...

Get a new health plan that fits your needs and budget at getcoveredhca.com. Visiting discloses to Enroll America you have been a patient of this hospital.

This is the hospital bill for Emergency services from August 21, 2015 through August 21, 2015.

Your current responsibility is \$ 411.00

*The amount you owe may include copay, deductibles or non-covered charges.

PAYMENT OPTIONS



Pay online at www.westhillshospital.com/bill.asp
Available 24/7

Pay with your smart phone by scanning this QR code



Pay-by-phone or call Customer Service at:
800-307-8016 Available Mon-Fri 8AM - 8PM ET



Mail in a check or credit card information with the section below.

Disponible asistencia para el idioma español.



DETACH HERE AND RETURN BOTTOM PORTION WITH PAYMENT

Patient	Account No.	Date Due	Amount Now Due	Amount Paid
KATHLEEN M GOLD	1002257625	Upon Receipt	\$ 411.00	\$

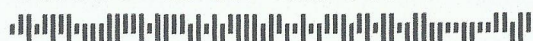
☐ Check here if your address or insurance information has changed.
Please indicate changes on the back of this page.

Please do not send cash.

Make checks payable to: WEST HILLS HOSPITAL



WEST HILLS HOSP & MED CT
01554
P.O. BOX 740766
CINCINNATI OH 45274-0766



Account No. _____

Expiration Date _____

Authorized Signature _____


GOLD KATHLEE 00100225762501554000000411000



CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

If you have new health insurance or a new address, please enter the information below.

NEW ADDRESS		CITY	STATE	ZIP CODE	NEW PHONE #
NEW EMAIL ADDRESS				<input type="checkbox"/> Check here to give us permission to use your email and phone number for billing purposes.	
POLICY HOLDER'S NAME/RELATIONSHIP TO PATIENT			POLICY ID #		GROUP #
EFFECTIVE DATE	BIRTH DATE OF INSURED		HMO/PPO/OTHER		INSURANCE PHONE #
IF GROUP INSURANCE, NAME OF GROUP (EMPLOYER, UNION/ASSOCIATION)					EMPLOYER PHONE #
INSURANCE COMPANY NAME			INSURANCE ADDRESS		
EMPLOYER			EMPLOYER ADDRESS		



Notice of Rights

Thank you for selecting this facility for your recent hospital services. Enclosed please find a summary of charges for your hospital visit. **Payment is due immediately.** Please be aware that this is a bill for hospital services only. There may be additional charges for services provided by physicians during your stay in the hospital, such as personal physicians, and any anesthesiologists, pathologists, radiologists, or other medical professionals who are not employees of the hospital. You may receive a separate bill for their services.

Summary of Your Rights: State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov.

Credit Counseling: This facility is aware that non-profit credit counseling services are currently available in this area and we encourage you to contact such services for assistance.

Health Insurance/Government Program Coverage: If you have private insurance, Medicare, Medi-Cal, Healthy Families, California Children's Services, or other state funded programs for your health coverage and have not provided that information to us, please call us at the number listed on the enclosed letter so that we may bill your services to the correct health coverage.

If you do not currently have health coverage, you may be eligible for one of these programs, a discount or our charity care program. You may obtain an application for the Medi-Cal or Healthy Families program by calling the same number. We would be happy to assist you.

Discounted and Charity Care: If you are uninsured or it is a financial hardship to pay your hospital bill, this hospital has a discount and charity care policy that may reduce or eliminate your financial responsibility to pay the bill. Eligibility is based upon your insurance coverage, financial hardship, and your income and family size. If you believe you may qualify for a discount or charity care, please contact our customer service representatives at the number listed on the enclosed letter.

New anh/chi khong the doc hay hieu duc tieng Anh hoac Tay Ban Nha, chung toi co the dich qua tieng Viet co quy vi. Xin goi dien thoai qua van phong lam viec o so tren mieng day nay.

Noticia de Derechos

Gracias por seleccionarnos para sus servicios medicos. El formulario adjunto solo refleja el monto adeudado en esta cuenta de su visita a nuestro hospital. **Agradecemos su pronta atencion a este balance pendiente.** Por favor esté enterado que esta cuenta es para servicios de hospital solamente. Es posible que haya cargos adicionales por servicios proporcionados por médicos durante su tiempo en el hospital, como médicos de cabecera, y como los anestesiólogos, los patólogos, los radiólogos, y otros profesionales médicos que no son empleados del hospital. Puede recibir una cuenta separada por esos servicios.

El resumen de Sus Derechos: La ley del estado y la ley federal requieren a collectores de deudas para tratarle justamente y prohíbe a collectores de deudas de hacer declaraciones falsas o amenazas de violencia, utilizando palabras obscenas o impropias, y haciendo comunicaciones impropias con partidos terceros, incluyendo su empleador. Solamente en circunstancias excepcionales, los collectores de deudas no le pueden contactar antes de 8:00 de la mañana ni después de 9:00 de la tarde. En general, un collector de deudas no puede dar información sobre su deuda a otra persona, unicamente a su abogado o su esposo/a. Un collector de deudas puede comunicarse con otra persona para confirmar su lugar o para realizar un juicio. Para más información sobre las actividades de cobro de deudas, usted puede contactar el Federal Trade Commission por teléfono al 1-877-FTC-HELP (382-4357) o en sitio web www.ftc.gov.

Consejero de Crédito: Esta facilidad esta consciente que existen consejeros de credito sin fines de lucro de servicios de asesoría de crédito disponibles en la actualidad en este campo y le animamos a contactar los servicios de asistencia.

Seguro Medico/Seguro Medico de Covertura de Programas del Gobierno: Si tiene seguro medico privado, Medicare, Medi-Cal, Healthy Families, California Children's Services, o otro programa de seguro medico del estado y no nos a proporcionado esa informacion, por favor llame al numero de telefono en esta carta para proporcionar la informacion requerida.

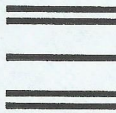
Si usted no tiene seguro medico en este momento, puede tener derechos a unos de estos programas, un descuento o para nuestro programa de caridad. Puede obtener una aplicación para Medi-Cal o para Healthy Families llamando al mismo número. Con gusto le ayudaremos.

Descuentos y Cuidado de Caridad: Si usted no tiene seguro medico o es una dificultad financiera a pagar su deuda, este hospital tiene un programa de descuentos o un programa de poliza de caridad que puede reducir o eliminar su responsabilidad financiera para pagar la deuda. Elegibilidad se basa en su cobertura de seguro medico, dificultad financiera, y en sus ingresos y tamaño de la familia. Si usted cree que puede calificar por algun descuento o cuidado de caridad, no dude en contactar nuestro servicio al cliente al número indicado en la carta.

FROM _____

☐ CHECK HERE IF ADDRESS CHANGE

159474



PLACE
FIRST
CLASS
POSTAGE
HERE

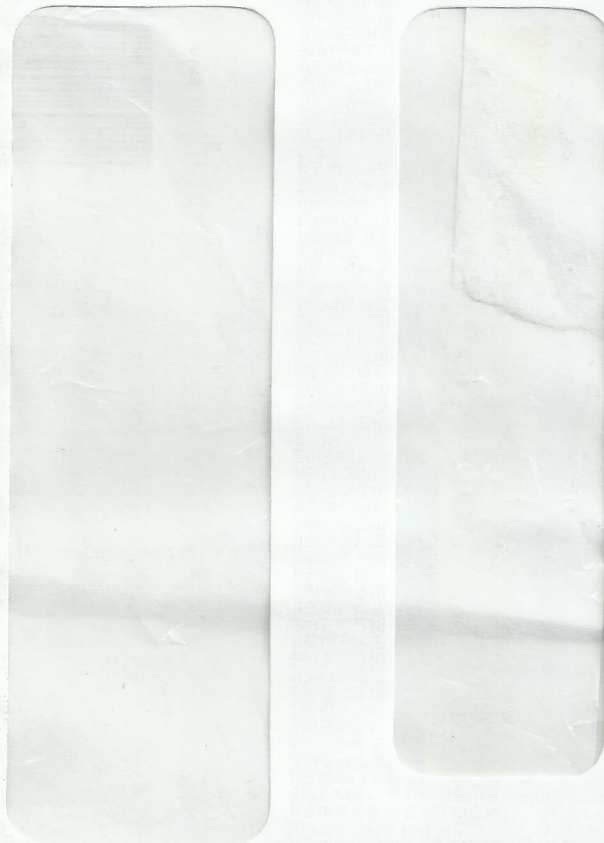
159474

471631



First Class Mail

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE PAID
43607
EMDEON EXB



203 IVJ-NP1 31345



MAKE CHECKS PAYABLE TO

West Hills Emergency Medical Associates
PO Box 4419
Woodland Hills CA 91365-4419



005241
0101

FOR BILLING QUESTIONS

Please Call Toll Free:

888-688-2938

Office Hours:

7:30-5:00 PDT/PST

Pay Online:

<https://pay.instamed.com/WHEMA>

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

KATHLEEN M GOLD
11100-8 SEPULVEDA BLVD
#512
MISSION HILLS, CA 91345

MASTERCARD VISA DISCOVER AMEX	
CARD NUMBER	AMOUNT
SIGNATURE	EXP DATE

NOTICE DATE 10/19/2015	PAY THIS AMOUNT \$837.00	ACCT # 2257625
PAYMENT DUE BY 11/03/2015	SHOW AMOUNT PAID HERE \$	

PLEASE DO NOT SEND CASH

WEST HILLS EMERGENCY MED ASSOC
PO BOX 4419
WOODLAND HILLS, CA 91365-4419



PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

655601 (PC1)

SECOND NOTICE

Patient Name:	KATHLEEN M GOLD	Notice Date:	10/19/2015
Account No:	2257625	Balance Due:	\$837.00

This is our second contact concerning your overdue account balance of \$837.00.

We are again asking that you pay your account balance in full to avoid further collection proceedings.

If your insurance company has not processed this account for payment, it is possible that we may not have received your insurance information. If you feel this is the case or you have any questions about your account, please call 888-688-2938 and speak with one of our representatives.

Esta es la segunda intencion de comunicarnos con usted acerca de su saldo vencido de \$837.00.

Le pedimos que pague el total de su cuenta para evitar futuros procedimientos de coleccion.

Si su aseguranza no ha procesado el pago de la cuenta, es posible que no hemos recibido la informacion de su aseguranza. Si este es el caso o tiene alguna pregunta, por favor llamar 888-688-2938 y hable con un representante.

Make Checks Payable To:	Pay Online at:
WEST HILLS EMERGENCY MED ASSOC PO BOX 4419 WOODLAND HILLS, CA 91365-4419	https://pay.instamed.com/WHEMA



2830-PHYCHCSTMT-2878363-2042470772-P; 13441614-1-244; 36710222-1; 1

000005254-A

**IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR
LAST STATEMENT, PLEASE INDICATE...**

PATIENT INFORMATION

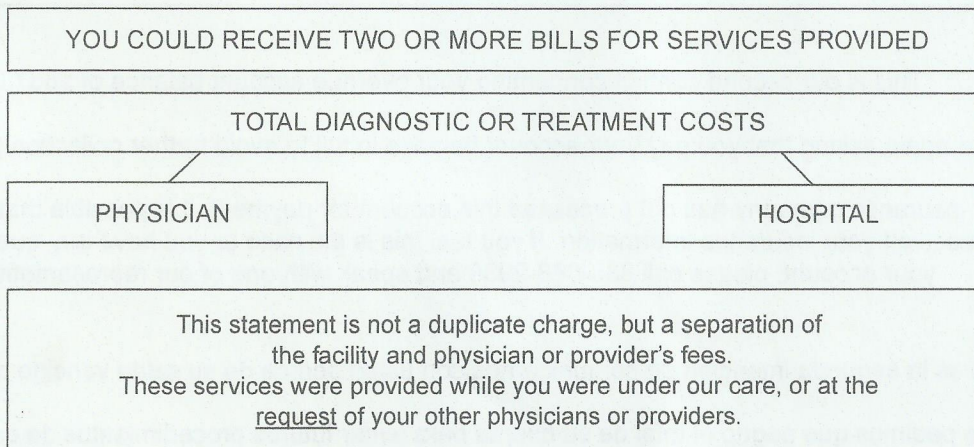
Your Name (Last, First, Middle Initial)		Date of Birth
Address		
City	State	Zip
Telephone ()		
Social Security #		
Employer's Name		Telephone ()
Employer's Address		
City	State	Zip
Please indicate if Applicable:		Date of Injury
<input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> WORKER'S COMPENSATION		

INSURANCE INFORMATION

Your PRIMARY Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number	Group Plan Number	
Your SECONDARY Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number	Group Plan Number	

"DETACH HERE AND RETURN ABOVE STUB"

FOR HOSPITAL OR OTHER FACILITY PATIENTS



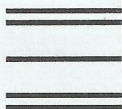
Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in the hospital or other facility.

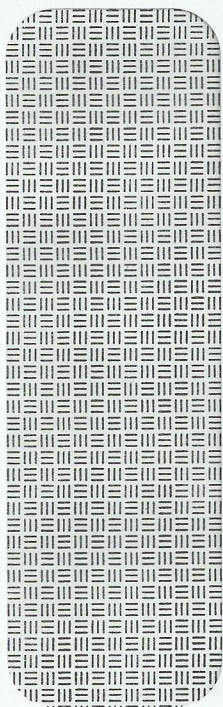
If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE
PHONE NUMBER ON THE REVERSE SIDE.

FROM: _____



PLACE
STAMP
HERE





ES09



First Class Mail

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE PAID
43607
EMDEON EXB

203 IVJ-NP1 51345





ES10

MAKE CHECKS PAYABLE TO

West Hills Emergency Medical Associates
PO Box 4419
Woodland Hills CA 91365-4419



004292
0101

FOR BILLING QUESTIONS**Please Call Toll Free:****888-688-2938****Office Hours:****7:30-5:00 PDT/PST****Pay Online:**<https://pay.instamed.com/WHEMA>

Please check box if address is incorrect or insurance
information has changed and indicate change(s) on reverse side.

KATHLEEN M GOLD
11100-8 SEPULVEDA BLVD
#512
MISSION HILLS, CA 91345

CARD NUMBER	AMOUNT
SIGNATURE	EXP DATE

NOTICE DATE 11/17/2015	PAY THIS AMOUNT \$837.00	ACCT # 2257625
PAYMENT DUE BY 12/02/2015		SHOW AMOUNT PAID HERE \$

PLEASE DO NOT SEND CASH

WEST HILLS EMERGENCY MED ASSOC
PO BOX 4419
WOODLAND HILLS, CA 91365-4419



PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

655609 (PC1)

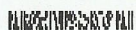
FINAL NOTICE

Patient Name:	KATHLEEN M GOLD	Notice Date:	11/17/2015
Account No:	2257625	Balance Due:	\$837.00

Our records indicate this account is seriously delinquent. Please contact our office to make payment arrangements. This is our final attempt to contact you to resolve this account. If no response is received within the next 15 days, we will be forced to send this account to an outside collection agency.

Nuestros archivos indican que su cuenta esta seriamente atrasada. Por favor llamenos para hacer un arreglo de pago. Este es el ultimo intento de nuestra parte para resolver esta cuenta si no recibimos respuesta en 15 dias nos veremos forzados a mandarla a una agencia de collecciones.

Make Checks Payable To:	Pay Online at:
WEST HILLS EMERGENCY MED ASSOC PO BOX 4419 WOODLAND HILLS, CA 91365-4419	https://pay.instamed.com/WHEMA



2830-PHYCHCSTMT-2913410-2062539426-P; 13574843-1-701; 36826948-1; 1

**IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR
LAST STATEMENT, PLEASE INDICATE ...**

PATIENT INFORMATION

Your Name (Last, First, Middle Initial)		Date of Birth
Address		
City	State	Zip
Telephone ()		
Social Security #		
Employer's Name		Telephone ()
Employer's Address		
City	State	Zip
Please indicate if Applicable:		Date of Injury
<input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> WORKER'S COMPENSATION		

INSURANCE INFORMATION

Your PRIMARY Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number	Group Plan Number	
Your SECONDARY Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number	Group Plan Number	

“DETACH HERE AND RETURN ABOVE STUB”

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED	
TOTAL DIAGNOSTIC OR TREATMENT COSTS	
PHYSICIAN	HOSPITAL
<p>This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the <u>request</u> of your other physicians or providers.</p>	

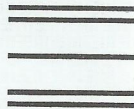
Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in the hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE
PHONE NUMBER ON THE REVERSE SIDE.

FROM: _____



PLACE
STAMP
HERE



111111

ES09


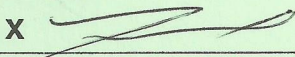


Sales Receipt			
Product	Sale Unit	Final	
Description	Qty	Price	Price

Total:	\$6.74
--------	--------

All sales final on stamps and postage

Customer Copy

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<p>■ Complete items 1, 2, and 3.</p> <p>■ Print your name and address on the reverse so that we can return the card to you.</p> <p>■ Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p>West Hills Emergency Medical Associates P.O. Box 4419 Woodland Hills, CA 91365 Attn: Monique</p>  <p>9590 9403 0126 5077 6365 52</p>		<p>A. Signature</p> <p>X </p> <p><input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name)</p> <p>Lerra Ferrer</p> <p>C. Date of Delivery</p> <p>OCT 21 2015</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>	
<p>2. Article Number (Transfer from service label)</p> <p>7015 0640 0005 0474 4229</p>		<p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™ <input type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Restricted Delivery</p>	
PS Form 3811, April 2015 PSN 7530-02-000-9053		Domestic Return Receipt	

U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only	
For delivery information, visit our website at www.usps.com ®.	
WOODLAND HILLS CA 91365	
OFFICIAL USE	
<p>Certified Mail Fee \$3.45</p> <p>Extra Services & Fees (check box, add fee as appropriate)</p> <p><input type="checkbox"/> Return Receipt (hardcopy) \$2.80</p> <p><input type="checkbox"/> Return Receipt (electronic) \$0.00</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery \$0.00</p> <p><input type="checkbox"/> Adult Signature Required \$N/A</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery \$N/A</p> <p>Postage \$0.49</p> <p>Total Postage and Fees \$6.74</p>	<p>0130</p> <p>02 Postmark Here</p> <p>10/20/2015</p>
<p>Sent To West Hills Emergency Medical Associates</p> <p>Street and Apt. No., or PO Box No. P.O. Box 4419</p> <p>City, State, ZIP+4® Woodland Hills CA 91365</p>	
PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions	



- Sender: Please print your name, address, and ZIP+4® in this box•

Kathy GORD
1110008 Sepulveda Blvd #512
Mission Hills, CA 91345

USPS TRACKING#



9590 9403 0126 5077 6365 52

Certified Mail service provides the following benefits:

- A receipt (this portion of the Certified Mail label).
- A unique identifier for your mailpiece.
- Electronic verification of delivery or attempted delivery.
- A record of delivery (including the recipient's signature) that is retained by the Postal Service™ for a specified period.

Important Reminders:

- You may purchase Certified Mail service with First-Class Mail®, First-Class Package Service®, or Priority Mail® service.
- Certified Mail service is *not* available for international mail.
- Insurance coverage is *not* available for purchase with Certified Mail service. However, the purchase of Certified Mail service does not change the insurance coverage automatically included with certain Priority Mail items.
- For an additional fee, and with a proper endorsement on the mailpiece, you may request the following services:
 - Return receipt service, which provides a record of delivery (including the recipient's signature). You can request a hardcopy return receipt or an electronic version. For a hardcopy return receipt, complete PS Form 3811, *Domestic Return Receipt*; attach PS Form 3811 to your mailpiece;

for an electronic return receipt, see a retail associate for assistance. To receive a duplicate return receipt for no additional fee, present this USPS®-postmarked Certified Mail receipt to the retail associate.

- Restricted delivery service, which provides delivery to the addressee specified by name, or to the addressee's authorized agent.
- Adult signature service, which requires the signee to be at least 21 years of age (not available at retail).
- Adult signature restricted delivery service, which requires the signee to be at least 21 years of age and provides delivery to the addressee specified by name, or to the addressee's authorized agent (not available at retail).
- To ensure that your Certified Mail receipt is accepted as legal proof of mailing, it should bear a USPS postmark. If you would like a postmark on this Certified Mail receipt, please present your Certified Mail item at a Post Office™ for postmarking. If you don't need a postmark on this Certified Mail receipt, detach the barcoded portion of this label, affix it to the mailpiece, apply appropriate postage, and deposit the mailpiece.

IMPORTANT: Save this receipt for your records.

West Hills Emergency Medical Associates
P.O. Box 4419
Woodland Hills, CA 91365-4419
Attn: Monique

October 20, 2015

Account #: 2257625

Dear Monique,

As per our conversation, I was attacked and because of that attack I had to go into the hospital. In the ER they sat with me and took my information to renew my Medi-Cal to pay for it. They said it wasn't a problem.

I don't know what happened with that application, did it not get renewed or is it in the process, I know there was a backlog of Medi-Cal so maybe that's what's going on, I don't really know I'm just guessing.

You can read about the backlog here:

<http://www.dailynews.com/general-news/20150122/californians-stuck-in-medi-cal-backlog-win-lawsuit-against-state>

Let me know.

Thank You,


Kathy Gold

West Hills Emergency Medical Associates
PO Box 4419
Woodland Hills CA 91365-4419

FOR BILLING QUESTIONS

Please Call Toll Free:

Office Hours:

Pay Online:

888-688-2938

7:30-5:00 PDT/PST

<https://pay.instamed.com/WHEMA>

This bill is due and payable upon receipt. Remit payment in the enclosed envelope. If you have insurance, please contact our office.

Account Detail

08/21/15
LEV 5, COMP HIST, EXAM, H \$785.00
EKG INTERPRETATION \$52.00
Total Charges \$837.00

Account Summary

Patient: KATHLEEN M GOLD
Guarantor: KATHLEEN M GOLD
Date of Service: 08/21/15
Account Number: 2257625
Total Charges: \$837.00
Total Payments:
Total Adjustments:

> **Your Balance at this time:** \$837.00

Location of Service

West Hills Hospital

Insurance Information

Primary Insurance NO INSURANCE

Secondary Insurance

If you are uninsured or have high medical costs, please contact our office at 888-688-2938 for information on discounts and programs for which you may be eligible, including the Medi-Cal program. If you have coverage, please tell us so that we may bill your plan.

PLEASE DETACH AND RETURN BOTTOM REMIT PORTION WITH YOUR PAYMENT

2830-PHYCHCSTMT-2837760-2019949580-P; 13240795-1-539; 36584671-1; 1

MAKE CHECKS PAYABLE TO

West Hills Emergency Medical Associates
PO Box 4419
Woodland Hills CA 91365-4419

FOR BILLING QUESTIONS

Please Call Toll Free:

Office Hours:

Pay Online:

888-688-2938

7:30-5:00 PDT/PST

<https://pay.instamed.com/WHEMA>

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

KATHLEEN M GOLD
11100-8 SEPULVEDA BLVD
#512
MISSION HILLS, CA 91345

 <input type="checkbox"/> MASTERCARD		 <input type="checkbox"/> VISA		 <input type="checkbox"/> DISCOVER		 <input type="checkbox"/> AMEX	
CARD NUMBER				AMOUNT			
SIGNATURE				EXP DATE			

NOTICE DATE	PAY THIS AMOUNT	ACCT #
09/17/15	\$837.00	2257625
PAYMENT DUE BY	SHOW AMOUNT PAID HERE \$	
10/02/2015		

PLEASE DO NOT SEND CASH

WEST HILLS EMERGENCY MED ASSOC
PO BOX 4419
WOODLAND HILLS, CA 91365-4419



004641
0101

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN

HOSPITAL

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the request of your other physicians or providers.

Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in the hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

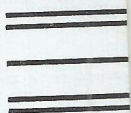
PATIENT INFORMATION

Your Name (Last, First, Middle Initial)		Date of Birth
Address		
City	State	Zip
Telephone ()		
Social Security #		
Employer's Name		Telephone ()
Employer's Address		
City	State	Zip
Please indicate if Applicable:		Date of Injury
<input type="checkbox"/> AUTO ACCIDENT		
<input type="checkbox"/> WORKER'S COMPENSATION		

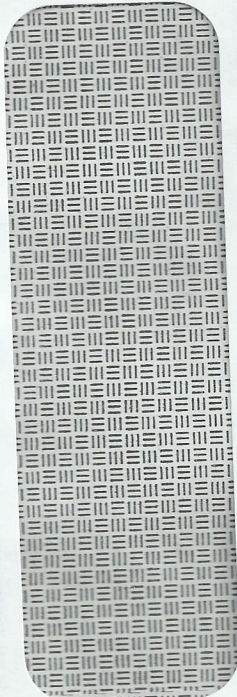
INSURANCE INFORMATION

Your PRIMARY Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number		Group Plan Number
Your SECONDARY Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number		Group Plan Number

FROM: _____

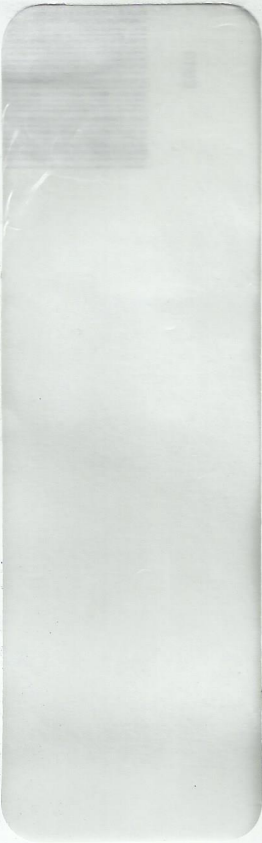


PLACE
STAMP
HERE



First Class Mail

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE PAID
43607
EMDEON EXB



017 6AF0AP1 51345



REV(04/09)U




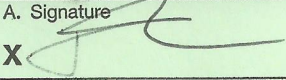
ES09



ES10



REV(08/07)

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY																
<p>■ Complete items 1, 2, and 3.</p> <p>■ Print your name and address on the reverse so that we can return the card to you.</p> <p>■ Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p style="font-size: 1.2em; margin-left: 20px;">Parallon 16800 Aston St Suite 200 Irvine, CA 92606 Attn Pat Flores</p> <div style="text-align: center; margin-top: 10px;">  9590 9403 0310 5155 6447 11 </div> <p>2. Article Number (Transfer from service label)</p> <div style="border: 1px solid black; padding: 2px; text-align: center; font-family: monospace; font-size: 0.9em;"> 7015 0920 0001 3866 3609 </div>	<p>A. Signature</p> <p>X  <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p style="margin-left: 20px;">Dulce Saverio</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type</p> <table style="width: 100%; font-size: 0.8em;"> <tr> <td><input type="checkbox"/> Adult Signature</td> <td><input type="checkbox"/> Priority Mail Express®</td> </tr> <tr> <td><input type="checkbox"/> Adult Signature Restricted Delivery</td> <td><input type="checkbox"/> Registered Mail™</td> </tr> <tr> <td><input type="checkbox"/> Certified Mail®</td> <td><input type="checkbox"/> Registered Mail Restricted Delivery</td> </tr> <tr> <td><input type="checkbox"/> Certified Mail Restricted Delivery</td> <td><input type="checkbox"/> Return Receipt for Merchandise</td> </tr> <tr> <td><input type="checkbox"/> Collect on Delivery</td> <td><input type="checkbox"/> Signature Confirmation™</td> </tr> <tr> <td><input type="checkbox"/> Collect on Delivery Restricted Delivery</td> <td><input type="checkbox"/> Signature Confirmation Restricted Delivery</td> </tr> <tr> <td><input type="checkbox"/> Mail</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Mail Restricted Delivery</td> <td></td> </tr> </table>	<input type="checkbox"/> Adult Signature	<input type="checkbox"/> Priority Mail Express®	<input type="checkbox"/> Adult Signature Restricted Delivery	<input type="checkbox"/> Registered Mail™	<input type="checkbox"/> Certified Mail®	<input type="checkbox"/> Registered Mail Restricted Delivery	<input type="checkbox"/> Certified Mail Restricted Delivery	<input type="checkbox"/> Return Receipt for Merchandise	<input type="checkbox"/> Collect on Delivery	<input type="checkbox"/> Signature Confirmation™	<input type="checkbox"/> Collect on Delivery Restricted Delivery	<input type="checkbox"/> Signature Confirmation Restricted Delivery	<input type="checkbox"/> Mail		<input type="checkbox"/> Mail Restricted Delivery	
<input type="checkbox"/> Adult Signature	<input type="checkbox"/> Priority Mail Express®																
<input type="checkbox"/> Adult Signature Restricted Delivery	<input type="checkbox"/> Registered Mail™																
<input type="checkbox"/> Certified Mail®	<input type="checkbox"/> Registered Mail Restricted Delivery																
<input type="checkbox"/> Certified Mail Restricted Delivery	<input type="checkbox"/> Return Receipt for Merchandise																
<input type="checkbox"/> Collect on Delivery	<input type="checkbox"/> Signature Confirmation™																
<input type="checkbox"/> Collect on Delivery Restricted Delivery	<input type="checkbox"/> Signature Confirmation Restricted Delivery																
<input type="checkbox"/> Mail																	
<input type="checkbox"/> Mail Restricted Delivery																	

PS Form 3811, April 2015 PSN 7530-02-000-9053 Domestic Return Receipt

7015 0920 0001 3866 3609

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
 Domestic Mail Only

For delivery information, visit our website at www.usps.com®.

IRVINE CA 92606

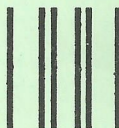
Postage	\$	\$3.45	0420 31 Postmark Here 09/12/2015
Certified Fee		\$2.80	
Return Receipt Fee (Endorsement Required)		\$0.00	
Restricted Delivery Fee (Endorsement Required)		N/A	
Total Postage & Fees	\$	\$6.74	

Sent to: Parallon Attn Pat Flores

Street & Apt. No.,
or PO Box No. 16800 Aston St #200

City, State, ZIP+4 Irvine, CA 92606

PS Form 3800, July 2014 See Reverse for Instructions



• Sender: Please print your name, address, and ZIP+4® in this box•

Kathy Gold
11100-8 Sepulveda Blvd ASK
Mission Hills, CA 91345

USPS TRACKING#



9590 9403 0310 5155 6447 11

Certified Mail service provides the following benefits:

- A Certified Mail receipt (this portion of the Certified Mail label).
- A unique identifier for your mailpiece.
- Electronic verification of delivery or attempted delivery.
- A record of delivery (including the recipient's signature) that is retained by the Postal Service® for a specified period.

Important Reminders:

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- Certified Mail service is *not* available for international mail.
- Insurance coverage is *not* available for purchase with Certified Mail service. However, the purchase of Certified Mail service does not change the insurance coverage automatically included with certain Priority Mail items.
- For an additional fee, you may request the following services:
 - Return receipt service, which provides you with a record of delivery (including the recipient's signature). You can request a hardcopy return receipt or an electronic version. For a hardcopy return receipt, complete PS Form 3811, *Domestic Return Receipt*; attach PS Form 3811 to your

mailpiece; include applicable postage to cover the return receipt service fee; and endorse the mailpiece "Return Receipt Requested," or see a retail associate for assistance. For an electronic return receipt, see a retail associate for assistance. To receive a duplicate return receipt, present this USPS®-postmarked Certified Mail receipt to the retail associate, who will provide a duplicate return receipt for no additional fee.

- Restricted delivery service, which provides delivery to the addressee specified by name, or to the addressee's authorized agent. Include applicable postage to cover the restricted delivery fee and endorse the mailpiece "Restricted Delivery," or see a retail associate for assistance.
- To ensure that your Certified Mail receipt is accepted as legal proof of mailing, it should bear a USPS postmark. If you would like a postmark on this Certified Mail receipt, please present your Certified Mail item at a Post Office™ for postmarking. If you don't need a postmark on this Certified Mail receipt, detach the barcoded portion of this label, affix it to the mailpiece, apply appropriate postage, and deposit the mailpiece.

IMPORTANT: Save this receipt for your records.

Kathy Gold
11100-8 Sepulveda Blvd, #512
Mission Hills, CA 91345

Parallon
16800 Aston St, Suite 200
Irvine, CA 92606
Attn Pat Flores

September 11, 2015

Dear Pat Flores,

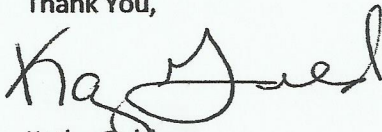
I received your letter dated August 25, 2015 and I called you twice and left you two messages in regards to medicaid application.

I also recieved a final notice dated 9/3/2015 for medical.

I really don't understand this at all as I did the paperwork for my medical renewal at West Hills Hospital in the emergency room. I only recieved one message from you which I called back last week.

Feel free to contact me via email at info @kathygold.com. Maybe you can email me the paperwork you need me to fill out.

Thank You,


Kathy Gold

16800 Aston Street Suite 200
Irvine CA 92606-4822



16800 Aston St. STE 200 • Irvine, CA 92606
(949) 430-5200 / (800) 494-4257 • Fax (949) 430-5220
RCPSDLMedicaidCustomerService@Parallon.com

Tuesday, August 25, 2015



Kathleen Gold
11100-8 Sepulveda Blvd # 512
Mission Hills CA 91345-1101

Re: Medicaid application on behalf of Kathleen Gold

Dear Kathleen Gold:

Our office has been asked by Hca to help you apply for Medicaid benefits for your hospitalization on 08/21/2015. Please be aware that you are responsible for payment of all medical bills relating to this hospital stay. However, if you qualify for Medicaid you will receive assistance to pay for your hospital bills, as well as other medical bills.

Our service is provided free of charge to you. We are not a collection agency!

Please call me within 15 days from the date of this letter by **09/09/2015**. I may be able to help you even if you have applied for Medicaid and your application was denied. **My toll-free telephone number is listed below.**

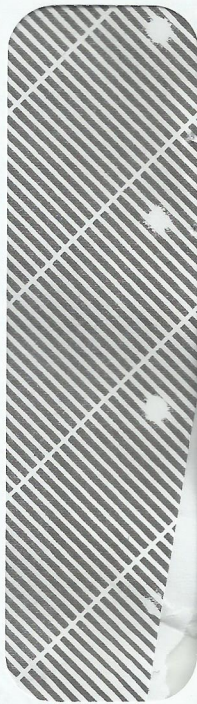
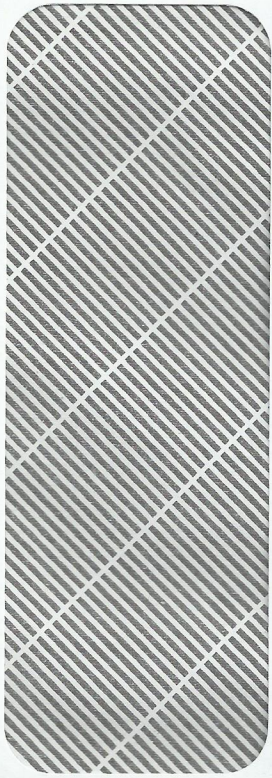
IMPORTANT: Please note, if you already have eligibility coverage to pay your hospital bill, please call me right away so that I can verify your benefits for billing.

Respectfully,

Pat Flores
Specialist
855-898-6257

FILE NUMBER: 1561749

668743155_213CSTOGC04INTROEN



0015082700

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
DPCH





16800 Aston St. STE 200 • Irvine, CA 92606
(949) 430-5200 / (800) 494-4257 • Fax (949) 430-5220

Thursday, September 03, 2015

Kathleen M Gold
11100-8 SEPULVEDA BLVD APT 512
MISSION HILLS, CA 91345

FINAL NOTICE

Re: Medi-Cal application on behalf of Kathleen M Gold
Hospital: HCA-West Hills Hospital and Medical Center (CA)
Admit Date: 8/21/2015

Dear Kathleen M Gold:

Our office is contracted with HCA-West Hills Hospital and Medical Center (CA) to help their patients apply for Medi-Cal benefits as well as resolve problems or difficulties with their existing Medi-Cal case.

There is no charge to you for this service. We are not a collection agency!

I have been trying to contact you in order to assist you in obtaining Medi-Cal coverage that will help you pay your outstanding medical bills. However, I have not heard from you and there is only a limited amount of time remaining to help you. I would very much like to assist you. If I do not hear from you within 10 days by **9/13/2015**, I will no longer be able to help you.

Please call me right away!

Respectfully,

Pat Flores
Medi-Cal Specialist
855-898-6257
949-430-5220 fax

FILE NUMBER: 1561749

15800 Aston Street, Suite 200 • Irvine, CA 92606



ZIP 92606
02 1W
0001379946SEP 03 2015

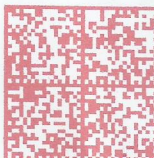


Figure 1 illustrates the experimental setup. A participant is seated at a table, looking at a screen. The screen displays a 3x3 grid of circles. The top row has three circles, the middle row has two circles, and the bottom row has one circle. The participant is looking at the screen from a distance. The screen is labeled 'Screen' and the participant is labeled 'Participant'.

[illegible]



West Hills Hosp. & Med Ctr
P O Box 923508
Norcross GA 30010-3508

November 12, 2015

KATHLEEN M GOLD
11100-8 SEPULVEDA BLVD
#512
MISSION HILLS, CA 91345

Patient Name: KATHLEEN M GOLD
Patient Account#: 1002257625
Service Date: 08/21/2015 - 08/21/2015

Dear KATHLEEN M GOLD:

This letter is being sent to notify you that your charity write off request has been denied due to the Financial Assistance Application not being received.

The account balance is due now. Payment may be made by check, money order, or credit card. If you are paying by check, please include your account number on the check.

You may appeal the denial decision by submitting a written request for review. Remember to include any previously missing or additional documentation to support your written request. This request must be returned within 30 days of the date of this letter. You will receive a written response to your appeal request within 30 days of the letter's receipt. If you have any question or concerns, please contact us at the number listed below.

If payment has been made since the date of this letter, please disregard this request. Thank you for choosing West Hills Hosp. & Med Ctr for your healthcare needs. If you have any questions or concerns, please contact us at the number listed below.

Sincerely,
Customer Service
Phone: 800-307-8016

Credit Card Authorization:

When paying by credit card, check the appropriate card and complete the information below.

☐ Visa ☐ American Express ☐ MasterCard ☐ Discover

Card Number: _____ Expiration _____

Date _____ Payment: \$ _____

Signature of Cardholder: _____

PARALLON®

Patient Account Services
5707 Peachtree Parkway
Suite 100
Norcross, GA 30092

1 1 / 1 8 / 1 5

**PRESORTED
FIRST CLASS**



U.S. POSTAGE® PITNEY BOWES



ZIP 30092 \$ 000.47¹
02 4W
0000332347 NOV 18 2015

60

JEE-IMP

91345



